

FILED DEC 18 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42436  
Registrar's No. 10441

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG.-DIST. NO. _____		Registrar's No. <b>10441</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>46 yrs.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2119</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4359 Cottage Avenue</b>				11. STREET ADDRESS (If rural, give location) <b>4359 Cottage Avenue</b>			
3. NAME OF DECEASED (Type or Print) <b>Lillie</b>		a. (First) <b>M.</b>		c. (Last) <b>Jones</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>12/5/50</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>5/12/84</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		9. AGE (In years last birthday) <b>66</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. BIRTHPLACE (State or foreign country) <b>Athens, Alabama</b>		13a. FATHER'S NAME <b>Horace Malone</b>		13b. MOTHER'S MAIDEN NAME <b>Lizzie McKinney</b>		14. NAME OF HUSBAND OR WIFE <b>Ananias Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Ethel Reet, 4359 Cottage Avenue</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>My pertussis Head Disease</b>  ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>				INTERVAL BETWEEN ONSET AND DEATH _____			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>H43X</b>					
22. I hereby certify that I attended the deceased from <b>10-20-1950</b> , to <b>12-5-1950</b> , that I last saw the deceased alive on <b>12-2-1950</b> , and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>J. B. Gates M.D.</b> (Degree or title)				23b. ADDRESS <b>3200 Lucas Avenue</b>		23c. DATE SIGNED <b>12/6/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>12/9/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>DEC 7 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Gates</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Chas. J. Gates, 4107 Finney Avenue</b>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed

*John K. Cunningham*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4476

P. O. Address. 4107 Finney Avenue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.